Preliminary Draft for Discussion
(Content and Recommendations Herein Have Not Been Approved by the Task Force)

IMPROVEMENT OF MANAGED CARE THROUGH COORDINATION AND INTEGRATION: CASE STUDY IN WOMEN'S HEALTH FINDINGS AND RECOMMENTATIONS

I. BACKGROUND

Managed care promises not only to contain health care costs, but to improve efficiency and enhance health status and consumer satisfaction through a focus on prevention and better integration and coordination of care. While many managed care organizations have successfully contained costs and have increased availability and coverage of routine care and preventive services,[1] they have gotten mixed reviews from a consumer satisfaction perspective and have largely failed to achieve many promised improvements over traditional unmanaged fee for service indemnity plans, particularly in the area of coordination of services. Utilization patterns continue to reflect the "fragmentation" that managed care seeks to correct. This paper explores some of the challenges managed care plans face in addressing women's health care needs, and suggests how coordination and integration in managed care could offer significant promise for improving health care for women.

II. MANAGED CARE - IDEALS AND CHALLENGES

As envisaged by the pioneering organizations, managed care offers the potential benefit of a coordinated system of health education, preventive care and treatment for illness. The overall premise is more proactive than that of traditional indemnity insurance; managed care plans seek to "optimize member health" rather than to simply treat members when they become sick. Experience to date has been mixed. Proponents of managed care point to success in the areas of cost savings, increased prevention and overall satisfaction levels similar to those of indemnity coverage, critics point to vocal consumer dissatisfaction with specific elements such as coverage limitations, curtailment of access to specialists, and broader use of non-physician providers.

Different health care systems, insurers and clinical authorities define and provide coverage for primary care in varying ways. The Institute of Medicine definition of "integrated accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community"[2] contrasts with the reality of most primary care provision in our current system.

Attempts to improve coordination and integration of care are appearing throughout the industry. One plan has developed an "adult primary care" model through which to more proactively coordinate the primary prevention and care needs of its adult member population. A similar focus on systematic management of chronic conditions in the member populations has become a common feature of managed care organizations through "disease management" programs which present a focal point within the plan for integration of multidisciplinary expertise around common chronic disease states.[3]

III. WOMEN'S HEALTH– CHALLENGES FOR MANAGED CARE

Women's health provides a very powerful example of both the failings and the potential of the managed care system to provide the benefits of integrated care. While most observers agree that managed care

[1] Schauffler HH, Brown ER and Rice T, "The State of Health Insurance in California, 1996," University of CA at Berkeley School of Public Health and UCLA Center for Health Policy Research, January, 1997, p. 43.
[2] Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, Eds. Committee on the Future of Primary Care, Division of Health Care Services, Institute of Medicine, Washington, DC, National Academy Press: 1996.
[3] "Disease management, a term invented by the Boston Consulting Group in 1993, refers to a complete, systematic approach to treating chronic diseases to reduce complications, overall utilization and cost.

plans have been very successful in making preventive care more broadly available,[4,5] consumers and critics contend that the system remains difficult to access and navigate. Several specific realities of the role of women in the health care system highlight both the challenges and potential for an integrated system of care:

- Women are the primary consumers of health care. They are responsible for coordinating care for most children and elders as well as for themselves. Enhancements to access through initiatives such as expansion of primary care sites, extended hours and telephone nurse advice lines can significantly affect their experience of the health care system.
- Fragmentation in clinical practice between the reproductive and non-reproductive elements of women's primary care is a well-documented problem. This fragmentation poses serious challenges to accessibility and accountability, and results in duplicative visits for many women.
- Women live longer than men, and have a higher incidence of chronic diseases such as osteoporosis, arthritis, diabetes, depression, multiple sclerosis, lupus, urinary incontinence, thyroid disease and breast and gynecological cancers, yet women have been the subject of far less clinical investigation. For example, a number of NIH funded studies on the prevention of cardiovascular disease in the 70's and 80's excluded women, despite the fact that approximately the same number of American men and women die of heart disease each year.[6,7] The potential for improving clinical care for women through increased research case management and chronic care programs is great.
- Policymakers, researchers and consumers have identified women's health as a significant issue and have delineated a number of areas in which plans could make specific improvements in both organization and practice. The subject of women's health is timely, and many have acknowledged that managed care organizations are well positioned to innovate in this area.

IV. INTEGRATION ANDCOORDINATION IN WOMEN'S HEALTH

Integration and coordination challenges in women's health can be categorized or characterized in many ways. The following examples will explore challenges in coverage and benefit design, the consumer/provider relationship and access to/utilization of care.

A. Coverage and Coordination of Care

Women's health has historically been delivered in a fragmented manner, encouraged by several phenomena. Medical training and specialization has separated reproductive health specialties from primary care for women; public financing for reproductive health for low income women separates reproductive health issues from other primary care; and politicization of reproductive services has promoted organizational segregation of providers and sites of care.[8] Fragmentation in Coverage

Much of the backlash against the broader managed care system has been directed at plans' use of the primary care "gatekeeper." The majority of managed care plans employing the gatekeeper model have

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[4] Reisinger, AL, "Health Insurance and Women's Access to Health Care," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 333.
[5] Schauffler HH, Brown ER and Rice T, "The State of Health Insurance in California, 1996," University of CA at Berkeley School of Public Health and UCLA Center for Health Policy Research, January, 1997, p. 43.
[6] Dickersin K and Schnaper L, "Reinventing Medical Research," in *Man Made Medicine: Women's Health, Public Policy and Reform*, Duke University Press, Durham: 1996, p. 59.
[7] Reidy Kelch D, "The Health of Older Women in California," California Women's Health Project, CEWAER, June 1996, p. 15. Note: A woman is twice as likely as a man to die within a few months of a heart attack.
[8] Weisman C, "Women's Use of Health Care," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 21

not convinced consumers that the primary care physician is performing a coordinating function – the overwhelming perception is that the gatekeeper is a barrier to choice and access. (See the Task Force's Physician Patient Relationship paper).

A number of states introduced bills under which managed care consumers would have the right to self-refer to specialists. This legislation reflects a very real concern on the part of consumers and presents interesting challenges for managed care organizations committed to pursuing coordinated and integrated care. The most prominent example highlights the fragmentation between reproductive and other health services for women. In the case of direct access to obstetrician/gynecologists, the legislation represents consumer demands for comprehensive primary care from organizations ostensibly organized to provide this care through coordination and integration of appropriate resources.

Benefit and Coverage Issues

Managed care has proven confusing to many consumers because of the broad variation in coverage and benefits. Results from the Commonwealth Fund survey indicated that many women (including between 7 and 15% of insured women depending on the specific service) do not seek basic, preventive care because they do not know whether their plan will pay for the services.[9] One out of three insured women surveyed reported that cost was a barrier to use of preventive services.[10]

Limitations on coverage for reproductive health services and mental health services represent two of the most significant barriers to improvement of the health status of women, and have been areas in which a great deal of the criticism of managed care has been focused. Demands for broader coverage of preventive services have often been countered, however, by lack of reliable outcomes measures and cost-effectiveness data for specific interventions. Development of a standard benefit package for *primary, preventive* care for women has been further confounded by leading authorities' variations in guidelines for screenings for services such as the Pap smear and clinical breast exam.[11]

B. Coordinated, Integrated Care – Provider Issues

The relationship between consumers and providers of care remains the primary relationship in the health care system. Integration of providers and the population includes elements as diverse as training of providers, recognition of the qualities and capabilities of a diversity of providers and relationship of providers with the health plans with which they contract. As noted earlier, women's health -- particularly women's primary care – presents some particular challenges for effective integration of providers and consumers. Studies show that women are more likely to receive primary care in a fragmented fashion (i.e. from both a generalist and a reproductive health specialist), to be dissatisfied with their provider and to request to switch physicians, usually over problems of communication.[12]

C. Access to and Utilization of Care

[9] Reisinger, AL, "Health Insurance and Women's Access to Health Care," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 60.
[10] Wyn R, Brown ER and Yu H, "Women's Use of Preventive Health Services," in *Women's Health: The Commonwealth Fund Survey* Johns Hopkins University Press, Baltimore: 1996, p. 67.
[11] Reisinger, AL, "Health Insurance and Women's Access to Health Care," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 54.
[12] Kaplan SH, Sullivan LM, Spetter D, Dukes KA, Khan A, Greenfield S, "Gender and Patterns of Physician Patient Communication," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 86.

Time and Cost Constraints

Time demands and constraints result in significant access issues for women: a 1994 study indicated that 29 percent of women 65 and under had not received care they knew they needed in the prior year due to time constraints.[13] The availability of services at times and sites convenient to women is clearly an important factor in improving utilization of care. Cost of care is also a strong predictor of utilization. The same study indicated that one out of three insured women surveyed reported that cost (i.e. copays and/or deductibles) was a barrier to use of preventive services.[14]

Authorized Providers/Sites of Care

Because issues of reproductive health and social determinants of health (e.g. poverty and domestic violence) have been central to the development of the women's health movement, community health centers and reproductive health clinics have played an important role in providing services to women, and their important contributions as elements of a comprehensive primary care system have been noted by many. Selective contracting in managed care often overlooks these resources because they are seen as providers of free care or care duplicative of that offered by the plan's "provider panel." According to a 1994 GHAA/Kaiser Family Foundation survey only 23% of HMOs had a contract with a family planning or abortion clinic.[15] Over half of the remaining plans, however, indicated that they "intend to contract with such clinics in the future." Studies show that women and their families continue to rely on these providers of care even when they are insured, because of their proximity to their homes, cost, availability of services not covered under their insurance, and concerns about confidentiality. Under the current system this often results in cost-shifting to publicly-funded clinics.

V. CONCLUSION

Effective integration and coordination of health care presents a significant challenge for those working to improve the managed care system. It is clear that the issues of integration and coordination of care commonly discussed in the context of managed care need to be broadened if they are to truly reflect the issues the comprehensive health needs and health-seeking behavior patterns of women.

The "model" managed care plan would use demographic and encounter information to identify patients in need of specific care or services, conduct proactive outreach, offer preventive services with minimal cost sharing and consider whether and how the primary users of services – women – will access services once they are made available. Managed care organizations have begun to develop innovative approaches to the challenges of integration and coordination of care, and should be encouraged to work in partnership with consumers, clinicians and other advocates for women's health to incorporate the diverse and important needs of women into these improvements.

VI. PRINCIPLES AND RECOMMENDATIONS

Specific recommendations for improvement of integration and coordination of women's health in the managed care system rests on several guiding principles.

Principles:

[13] Commonwealth – get cite.

[14] Wyn R, Brown ER and Yu H, "Women's Use of Preventive Health Services," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 67.

[15] Gold, RB and Richards CL, "Improving the Fit, Reproductive Health in Managed Care Settings," The Alan Guttmacher Institute, New York: 1996, p. 24.

- The managed care system will only deliver on its promise of optimizing member health while containing health care costs if it operates upon a foundation of coordinated, integrated care
- Comprehensive primary care addresses both biomedical and psychosocial factors in health and wellness
- Provision of comprehensive primary care and coordinated care of chronic diseases will improve health status and outcomes
- Womens' utilization of primary and preventive care is highly dependent on accessibility. As women are responsible for coordinating care for both themselves and most dependents, managed care organizations must not simply offer services, but must consider when, where and by whom services are being offered if they wish to achieve the full benefits of these interventions

Recommendations:

- Managed care organizations should be encouraged to coordinate and integrate care around the needs of members. Advocacy groups should work with purchasers and accrediting organizations to define member survey questions that measure the extent to which MCOs are effectively integrating and coordinating members' care, including services exclusive to women and incorporating measures of under and over-utilization. Because HEDIS measures are used widely by purchasers and consumers to asses health plan performance, the elements included strongly influence health plans' priorities in service delivery and quality improvement, and they serve as important leverage points for influencing both plan and provider behavior.
- Recognizing that members, particularly women and adolescents, are likely to forego care because of issues of scheduling and confidentiality, managed care organizations should address these specifically as issues of access. When managed care organizations refer members to community-based clinics for "medically necessary" services not available within the plan (or recognize that many of their members are self-referring to these facilities), MCOs should be encouraged to provide an option that allows reimbursement for necessary primary and preventive care at alternative sites.
- Plans should be encouraged by purchasers to provide information to all plan enrollees, not only to the primary plan subscriber, to ensure that those plan members covered as dependents are aware of the services available to them.
- The division between primary care and routine reproductive care for women results in fragmentation of services, unnecessary duplication of services, inconvenience and cost for members and increased costs for insurers. To alleviate these problems:
  - Primary care training programs should incorporate the full range of primary health needs of men and women, and should prepare practitioners or design practitioner teams to provide for the totality of these needs.
  - MCOs should ensure that primary care practitioners or teams made available to members are capable of providing the full range of necessary primary care services to avoid duplication that is costly to both plans and members. MCOs should be encouraged to require generalists who wish to provide primary care to women to demonstrate competency in basic aspects of gynecological care such as breast and pelvic exam, contraceptive management, and initial management of common gynecological problems.
- Collaboration between the public and private sector of consistent standards and development of evidence-based, gender-specific practice guidelines should be encouraged.

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BACKGROUND PAPER

I. INTRODUCTION

Managed care promises not only to contain health care costs, but also to improve efficiency and enhance health status and consumer satisfaction through a focus on prevention and better integration and coordination of care. While many managed care organizations have successfully contained costs and have increased availability and coverage of routine care and preventive services,[16] they have gotten mixed reviews from a consumer satisfaction perspective and have largely failed to achieve many promised improvements over traditional fee for service (FFS) plans, particularly in the area of coordination of services. While many plans can point to significant improvements over traditional indemnity plans in availability of services, utilization patterns continue to reflect the "fragmentation" that managed care seeks to correct.

Significant areas of opportunity for improvement exist in several areas in the managed care delivery system. Development of a truly comprehensive system requires effective integration along many dimensions, including the definition of comprehensive care, the provision of care and access to and utilization of care.

Women's health presents a particularly important case study in integration and coordination of care, as women are the primary consumers of health care (for both themselves and their families) and make up a majority of managed care enrollees. Women live longer than men, suffer from more chronic illness and have been the subject of less clinical investigation.

This paper will explore the ideals of coordination and integration of care in managed care systems. The potential for improvement of managed care through coordination and integration of care in both the early group and staff model systems, which were conceived and designed around these principles and the newer, "carrier HMOs," (generally network and IPA models which contract with various medical groups), which are often not designed around these principles will be considered. Following a brief discussion of existing patterns of care in managed care systems, examples from women's health in the broad areas of "coverage and comprehensiveness of services," "access to and utilization of care" and "providers of care in a managed care system" will be considered.

II. MANAGED CARE - IDEALS AND CHALLENGES

As envisaged by the pioneering organizations, managed care rests upon the tenets of population health, and offers the potential benefit of providing a coordinated system of health education, preventive care and treatment for illness. The overall premise is more proactive than that of traditional indemnity insurance; managed care plans seek to "optimize member health" rather than to simply treat members when they become sick. Experience to date has been mixed. While proponents of managed care point to success in the areas of cost savings, increased prevention and health promotion and overall satisfaction levels similar to those of indemnity coverage, critics point to vocal consumer dissatisfaction with specific elements such as coverage limitations, curtailment of access to specialists, and broader use of non-physician providers.

[16] Schauffler HH, Brown ER and Rice T, "The State of Health Insurance in California, 1996," University of CA at Berkeley School of Public Health and UCLA Center for Health Policy Research, January, 1997, p. 43.

A. Defining Comprehensive Primary Care

There is a great deal of variation in the manner in which different health care systems, insurers and clinical authorities define and provide coverage for primary care. The Institute of Medicine definition of "integrated accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community"[17] challenges the reality of most primary care provision in our current system.

HMOs, the most tightly managed form of managed care, use the primary care provider (PCP) as the members' point of entry into the health care system and point of departure for receipt of more specialized care.[18] Because the PCP controls the member's access to the broader system of care, the system's effectiveness in helping the member to achieve his or her optimal health status relies heavily on how the role of this practitioner or team is conceived and executed. The primary care model in practice throughout most of the past several decades, including the period heavily influenced by managed care, has been largely informed by a biomedical model, has included very little training for "gatekeeping" activities, and has rested on research focused primarily on men.

Newer conceptions of women's health take a broader approach to the definition of primary care. Under these new definitions, women's comprehensive primary care includes a broad range of components, including: medical disease areas (such as cardiology and rheumatology), reproductive care (including general gynecology, obstetrics, and oncology), psychology and behavioral medicine (including depression, alcohol and drug abuse, eating disorders, and domestic violence) and preventive medicine (including cancer screening).[19] This "holistic" definition of primary care – a definition that corresponds more closely with the managed care goals of optimizing member health - presents significant implications for the task of integrating and coordinating needed care. The primary care needs of women also vary significantly across the different stages of their lives, and the most effective care model and provider team may be quite different at each of these stages.

B. Existing Patterns of Care

While many managed care organizations have worked to develop clear coverage and referral policies and processes, consumers continue to be extremely frustrated with many aspects of plan and provider operations. Consumers often don't understand plan communications, don't know what services are covered, are frustrated when their plan and their doctor do not communicate about or agree on treatment options, and are confused by referral and authorization procedures. In the ideal integrated delivery system, the various components (insurers, providers and facilities) work systematically together in pursuit of common goals, linked together by incentives and information, in the interest of providing the patient with care that is effective in both preventing and treating illness and constraining costs. While few organizations have achieved this ideal, many are beginning to develop the systems they feel are necessary to do so. Alignment of incentives and integration of the various components of the increasingly complex health care delivery system are the primary levers through which players in the health care system are attempting to improve managed care.

[17] Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, Eds. Committee on the Future of Primary Care, Division of Health Care Services, Institute of Medicine, Washington, DC, National Academy Press: 1996.
[18] Members of less organized forms of managed care, particularly PPOs, may use the primary care practitioner or team as the focal point for primary care, but do not rely on the PCP to grant referrals to specialized care.
[19] Carlson, KJ, Eisenstat, SA, Frigoletto, FD, Schiff, I. *Primary Care of Women*. St. Louis, Mosby: 1995.

C. Organizational Challenges for Health Plans

Many traditional indemnity insurers entered managed care by simply developing gatekeepers and utilization review (UR) mechanisms in conjunction with capitation or discounted fee for service. These systems differ significantly from the group and staff model HMOs, which were developed as managed care plans and are managed "from the ground up." While use of UR and capitation alone can result in decreased costs and elimination of some utilization, they are not sufficient to create the organizational change necessary to realize the potential for increased patient satisfaction and improved outcomes of truly integrated care.

An effective managed care system requires much more than a network of providers and an insurance mechanism. Additional necessary elements include information systems for enrollment, billing and patient tracking; recruitment and contracting with providers and plans; calculation of payment rates, often including rates for per-capita pre-payment; parameters on access and quality assurance; data collection and monitoring systems to detect access and quality of care problems; and enrollment and education of members.

While many managed care organizations are developing the information and organizational capacities to perform this range of tasks, many of the aspects of traditional indemnity coverage which resulted in patient dissatisfaction and elevated costs – namely lack of coordination of care, missed opportunities for process improvement and wide variations in practice – remain significant issues under managed care.

D. Coordination and Integration Trends in Managed Care

Managed care plans have always asserted that optimizing member health through strong prevention and primary care programs will lead to cost savings, but have focused much of their effort on eliminating "unnecessary" costs at the population and system levels through utilization review and management. As many of the initial efficiencies and cost savings of controlling access and utilization have been realized, plans have begun to focus on improving health and satisfaction at the member level. Prevention programs focused on population health concepts (i.e. more proactive outreach programs for immunizations, screenings and health promotion) customer segmentation and personalized attention from member services departments have become more prevalent features of managed care plans.

Attempts to improve coordination and integration of care are appearing throughout the industry. One plan has developed an "adult primary care" model through which to more proactively coordinate the primary prevention and care needs of its adult member population. A similar focus on systematic management of chronic conditions in the member populations has become a common feature of managed care organizations through "disease management" programs,[20] which present a focal point within the plan for integration of multidisciplinary expertise around common chronic disease states. While many feel that these programs improve health status and outcomes by proactively managing care and treatment, others are concerned that they risk being treated as "carve outs" by plans and can result in fragmentation of care.

Many managed care plans have begun to devote resources to coordination and integration of services for individual members and groups with common health needs. Both within and outside of disease management program, personal member representatives – essentially administrative case managers – are becoming a more prominent feature of plans. While "case management" has long been used to coordinate health and social services, it has not been a component of the traditional primary care model.

[20] A term invented by the Boston Consulting Group in 1993, "disease management" refers to a complete, systematic approach to treating chronic diseases to reduce complications, overall utilization and cost.

The goals of case management -- coordination of complex, fragmented services to meet the needs of the client while controlling costs -- are consistent with the goals of managed care.

Women's health programs, both within managed care organizations and as independent components of the health care delivery system, have been an area of rapid development and innovation in both non-profit and for-profit plans. These initiatives propose to provide "women-centered" care by focusing on both the care integration needs of women and women's attitudes and preferences regarding how, where and by whom care is delivered. Health plans have offered women-only health centers as options for female members and have begun offering screening promotions such as "mobile" mammogram clinics. Medical groups and management organizations devoted exclusively to women's health have become more prevalent and community reproductive health centers have begun to provide a broader range of primary care services to increase their likelihood of retaining contracts with managed care organizations.

III. WOMEN'S HEALTH – CHALLENGES FOR MANAGED CARE

Women's health provides a very powerful example of both the failings and the potential of managed care systems to provide the benefits of integrated care. While most observers agree that managed care plans have been very successful in making preventive care more broadly available,[21,22] consumers and critics contend that the system remains difficult to access and navigate. Several specific realities of the role of women in the health care system highlight both the challenges and potential for improvement through integration of the elements of comprehensive care:

- Women are the primary consumers of health care. They are responsible for coordinating care for most children and elders as well as for themselves. Enhancements to access through initiatives such as expansion of primary care sites, extended hours and telephone nurse advice lines can significantly impact their experience of the health care system.
- Fragmentation in clinical practice between the reproductive and non-reproductive elements of women's primary care is a well-documented problem. This fragmentation poses serious challenges to accessibility and accountability, and results in duplicative visits for many women.
- Women live longer than men, and have a higher incidence of chronic diseases such as osteoporosis, arthritis, diabetes, depression, multiple sclerosis, lupus, urinary incontinence, thyroid disease and breast and gynecological cancers, yet women have been the subject of far less clinical investigation. For example, a number of NIH funded studies on the prevention of cardiovascular disease in the 70's and 80's excluded women, despite the fact that approximately the same number of American men and women die of heart disease each year.[23] The potential for improving clinical care for women through increased research case management and chronic care programs is great.
- Policymakers, researchers and consumers have identified women's health as a significant issue and have delineated a number of areas in which plans could make specific improvements in both organization and practice. The subject of women's health is timely, and many have acknowledged that managed care organizations are well positioned to innovate in this area.

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[21] Reisinger, AL, "Health Insurance and Women's Access to Health Care," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 333.

[22] Schauffler HH, Brown ER and Rice T, "The State of Health Insurance in California, 1996," University of CA at Berkeley School of Public Health and UCLA Center for Health Policy Research, January, 1997, p. 43.

[23] Dickersin K and Schnaper L, "Reinventing Medical Research," in *Man Made Medicine: Women's Health, Public Policy and Reform*, Duke University Press, Durham: 1996, p. 59.

IV. INTEGRATION AND COORDINATION IN WOMEN'S HEALTH

Integration and coordination challenges in women's health can be categorized or characterized in many ways. The following examples will explore challenges in coverage and benefit design, the consumer/provider relationship and access to/utilization of care.

A. Coverage and Coordination of Care

The issue of comprehensive primary care in women's health is of particular importance because of the historical fragmentation of services in women's health. Fragmentation in women's health care delivery is encouraged by several phenomena. Medical training and specialization has separated reproductive health specialties from primary care for women; public financing for reproductive health for low income women separates reproductive health issues from other primary care; and politicization of certain reproductive services has promoted organizational segregation of providers and sites of care.[24]

Fragmentation in Coverage for Women's Primary Care

Much of the backlash against managed care has been directed at plans' use of the primary care "gatekeeper." The majority of managed care plans employing the gatekeeper model have not convinced consumers that the primary care physician is performing a coordinating function – the overwhelming perception is that the gatekeeper is a barrier to choice and access. (See the Task Force's Physician Patient Relationship paper).

Consumer reaction to managed care practices has resulted in a number of "direct access" legislation proposals across the country. In the 1996-1997 legislative session, a number of states introduced bills under which managed care consumers would have the right to self-refer to specialists. This legislation reflects a very real concern on the part of consumers and presents some interesting challenges for managed care organizations committed to pursuing coordinated and integrated care.

The most prominent example highlights the fragmentation between reproductive and other health services for women. The issue of legislative mandates requiring that plans allow women to "self refer" to ob/gyns provides an interesting illustration of the tradeoffs inherent in using direct access legislation to "force" health plans to provide access to specialty care. In the case of direct access to ob/gyns, the legislation represents consumer demands for comprehensive primary care from organizations ostensibly organized to provide this care through coordination and integration of appropriate resources.

Women in managed care plans are often assigned to "generalist" primary care physicians who are unable to perform routine reproductive health tests and procedures. In order to obtain comprehensive primary care, they must be referred by their primary care provider to a provider who offers these services. Many organizations have attempted to solve this problem (and to respond to preferences of women members) by allowing women to choose an ob/gyn as their primary care provider. Many women who accept this option, however, chose ob/gyns who are not trained or do not choose to conduct non-reproductive primary health tests and screenings. These women thus must also see multiple primary care providers. The Commonwealth Fund Study of Women's Health[25] revealed that one third of women regularly seek

[24] Weisman C, "Women's Use of Health Care," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 21

[25] The Commonwealth Fund Survey of Women's Health was the first national survey of American women 18 and over attempted to gain insight into the physical and mental health of women, use of health services barriers to care and health habits. This study covered both women enrolled in HMOs and women in FFS plans. The study found that women outside of HMOs were more likely to have an ob/gyn as their primary care physician. Women in HMOs were more likely to have an ob/gyn in addition to a family practitioner or other primary care practitioner. Preventive services were more likely to be provided to women in HMOs, but these women were also more likely to report not having gotten needed medical care in the past year (reasons cited included high cost, inability to get an appointment and lack of coverage for the care in question).

care from both a primary care physician and an ob-gyn; these women made 25% more primary care visits than women seeing only one practitioner[26]. Use rates for different procedures – all of which are elements of comprehensive primary care – also vary by specialty of provider. Among nonelderly women, those with an ob/gyn as a primary care provider had higher rates of Pap smear screening and breast exams, while those with an internist or general practitioner as a PCP had higher rates of mammography, blood pressure screening and blood cholesterol screening[27]. Receiving care from both a generalist PCP and an ob/gyn increased the number of recommended preventive services received[28]. Given these findings, it is not surprising to note that the study also found that utilization of both a generalist and reproductive primary care provider was positively correlated with both income and education[29].

By coordinating care, either through a team approach or through cross-training of primary care providers, plans could provide women with greater continuity of care and enhanced access and eliminate duplicate visits that are costly to both the delivery system and the patient. While the legislative "direct access" strategy arguably provides women the access to reproductive care they need, it undermines important principles of the managed care system and may not result in women (particular those who are poor and/or have a low educational level) receiving more comprehensive services. Unless managed care organizations are able to establish a higher level of trust with consumers and provide them with the assurance that the system is designed to provide comprehensive services, "self-referral" and direct access demands will continue to offer incremental solutions to the need for comprehensive primary care for women.

Benefit and Coverage Issues

As mentioned earlier, managed care has proven confusing to many consumers because of the broad variation in coverage and benefits (benefit design can vary significantly at any combination of the purchaser, plan and provider levels). Results from the Commonwealth Fund survey indicated that many women (including between 7 and 15% of insured women depending on the specific service) do not seek basic, preventive care because they do not know whether their plan will pay for the services[30]. One out of three insured women surveyed reported that cost (i.e. copays and deductibles) was a barrier to use of preventive services[31].

Limitations on coverage for reproductive health services and mental health services represent two of the most significant barriers to improvement of the health status of women, and have been areas in which a great deal of the criticism of managed care has been focused. Coverage of preventive services such as pap smears and mammograms has consistently shown to be broader under managed care than under indemnity insurance[32]. Demands for broader coverage of preventive services have often been countered, however, by lack of reliable outcomes measures and cost-effectiveness data for specific interventions. Development of a standard benefit package for *primary, preventive* care for women has been

[26] Weisman CS, Casard SD. Plichta SB, "Types of physicians used by women for regular health care: implications for services received," J Women's Health. 1995:4:407-16.
[27] Falik MM and Collins KS, Eds. *Women's Health, The Commonwealth Fund Survey*, Baltimore: The Johns Hopkins University Press, 1996, p. 63.
[28] Weisman, CS, "Women's Use of Health Care," in *Women's Health, The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 37.
[29] Ibid. p. 32.
[30] Reisinger, AL, "Health Insurance and Women's Access to Health Care," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 60.
[31] Wyn R, Brown ER and Yu H, "Women's Use of Preventive Health Services," in *Women's Health: The Commonwealth Fund Survey* Johns Hopkins University Press, Baltimore: 1996, p. 67.
[32] Reisinger, AL, "Health Insurance and Women's Access to Health Care," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 333

confounded by leading authorities' variations in guidelines for screenings for services such as the Pap smear and clinical breast exam.[33] Increased, targeted studies of the benefits of comprehensive preventive services and interventions are needed if preventive care is to be expanded.

Mental health presents a striking example of how coverage decisions can confound appropriate coordination of care. Depression is twice as common in women as in men, and depressed primary care patients use two to three times the medical resources as their non-depressed counterparts.[34] Many managed care plans will provide only limited coverage for mental health services, but will continue to cover the (more expensive) somatic manifestations of the mental illness. Delivery and financing of care have been structured around acute, curative care, with a bias toward funding for inpatient care and procedures.[35] Medical studies have overwhelmingly focused on the health status and needs of men, and have not until recently acknowledged that women are sufficiently different to include them as subjects or issue specific guidelines for their treatment. For example, guidelines published as recently as 1996 by the Agency for Health Care Policy and Research for detection and treatment of depression in primary care are missing reference to the profound impact of gender based violence in the incidence of depression among women[36] and fail to delineate the differences in selecting and prescribing psychotropic medications for women and men.[37]

B. Coordinated, Integrated Care – Provider Issues

The relationship between consumers and providers of care remains the primary relationship in the health care system. Integration of providers and the population includes elements as diverse as training of providers, recognition of the qualities and capabilities of a diversity of providers and relationship of providers with the health plans with which they contract. As noted earlier, women's health -- particularly women's primary care – presents particular challenges for effective integration of providers and consumers. Studies show that women are more likely to receive primary care in a fragmented fashion (i.e. from both a generalist and a reproductive health specialist), to be dissatisfied with their provider and to request to switch physicians, usually over problems of communication.[38] Women are also more likely to choose to utilize advanced practice nurses as primary care providers; thus the challenges of integrating non-physician providers effectively into a comprehensive system of care will disproportionately affect women. Studies show that advanced practice nurses score higher on health promotion and quality of care measures than physicians.[39]

The managed care system has promoted short office visits for patients and clinicians – these productivity pressures on clinicians have been the focus of concern for consumers and concern some clinicians who feel that they do not have enough time to involve patients effectively in treatment decisions. Some managed care organizations have responded to this concern by developing managed care teams including a range of providers, including nurses and social workers, with the goal of more effectively serving patients' needs for information and treatment planning. Continuity of care has also been an issue of

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[33] Ibid. p. 54.
[34] Goldberg RJ, "Psychiatry and the Practice of Medicine: The need to integrate psychiatry into comprehensive medical care." *Southern Medical Journal* 1995; 88:260-67.
[35] Wyn R, and Brown ER, "Women's Health, Key Issues in Access to Insurance Coverage and Services Among Non-Elderly Women,"
[36] McGrath E, Keita GP, Strickland BR, Russo NF. "Women and Depression: Risk Factors and Treatment Issues." Am Psychological Association, 1990.
[37] Jensvold, Halbreich and Hamilton *Psychopharmacology and Women: Sex, Gender and Hormones* Washington, DC, American Psychiatric Press, Inc., 1996
[38] Kaplan SH, Sullivan LM, Spetter D, Dukes KA, Khan A, Greenfield S, "Gender and Patterns of Physician Patient Communication," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 86.
[39] Brown SA, Grimes DE, "Nurse practitioners and certified nurse midwives – A meta-analysis of studies on nurses in primary care roles." Washington, DC: American Nurses Publishing: 1993.

concern for many under managed care. As employers and members switch plans with greater frequency and plans' and providers' contracts change, many consumers find themselves having to switch providers. (See the Task Force's Physician Patient Relationship paper for further discussion of these issues.)

Training of Providers

Primary health care for women has traditionally been provided by both generalists (internists, family practitioners and general practitioners) and obstetrician-gynecologists (ob/gyns). The services offered by these two groups overlap in several areas, but women have customarily received medical care for episodic and chronic nonreproductive illness from the first group and gynecological and obstetrical care from the latter.[40] Under current medical training, each specialty has some advantages and some disadvantages in serving as primary care provider.

The historical failure of the medical education system to address women's comprehensive primary care needs has been noted at a systemic level: The Council on Graduate Medical Education, The Federated Council of Internal Medicine, The Council on Graduate Medical Education, the Federated Council on Internal Medicine, the American College of Obstetricians and Gynecologists, the American Association of Family Practitioners and the National Academy of Women's Health in Medical Education have all delineated competencies in women's health that cross traditional professional boundaries. Changes in the medical education system are beginning to address the fragmentation problem in women's health care. The specialty of family practice has trained providers of both general and gynecological care (and often obstetrics). Some residency programs in internal medicine have included training in primary care gynecology to enable graduates to provide routine gynecological care. Finally, since 1995 residency training for obstetrician-gynecologists has included a non-reproductive primary care component, and postgraduate programs in general primary care have proliferated. The medical boards now include a section on women's health care.[41] The nursing profession has historically placed more of a focus on women's health, developing graduate programs, conducting research and serving as advocates for women's health.

Cultural competency

Women's health provides a particularly instructive case study in that it forces a consideration of the challenges the health care system faces as it attempts to adapt primary care concepts to account for behavioral, social and cultural factors. Many of the shortcomings in the current system can only be remedied through recognition of women's health seeking behavior and coordination and integration of care that responds to their needs in an effective, culturally competent manner across the different phases of life.

One prominent example in this area is the issue of sexually transmitted diseases (STDs). Though five of the 10 most frequently reported diseases in the US in 1995 were STDs, recent studies show that prevention and treatment of STDs are not being integrated into routine primary care because of service fragmentation, inadequate provider training, provider discomfort in addressing issues of sexual behavior and biases regarding which patients are at risk.[42] The Kaiser Study found that only 12% of women aged 18-44 who had a first visit with a health provider in the past year reported that their provider had raised the issue of STDs as part of their routine reproductive care. While STDs are a common component of outpatient medical practice, fewer than 20% of medical education programs provide adequate training in

[40] Clancy CM and Massion CT. "American Women's Health Care: A Patchwork Quilt with Gaps" JAMA 1992; 268:1918-20.
[41]
[42] "Talking About STDs With Health Professionals: Women's Experiences," Kaiser Family Foundation, 1997.

taking sexual histories and in STD evaluation and treatment.[43] In this area, as in many areas of reproductive health and sexuality, "mainstream" primary care providers are not adequately trained or motivated to provide for the needs of a large constituency. The knowledge and skills to provide STD and other "sensitive" services do exist in clinical practice, but often reside in practices excluded from the majority of managed care provider networks. Recognizing this problem, the state of CA has required Medi-Cal managed care organizations in 12 counties to subcontract with local health departments for several public health services, including STD-related care.[44]

Coordination of Providers and Managed Care Organizations

Studies have shown that the single greatest determining factor in women's receipt of routine, clinical preventive services is whether they have a regular provider of care or a regular "place that they receive care" – i.e. a relationship with their health care provider at either the individual provider or clinic level.[45] While uninsured women are more likely to lack a regular source of care, the problem is quite prevalent among the insured population: The Commonwealth Fund survey found that one in five nonelderly insured women in the US did not have a regular connection to the health care system.[46] As the trend in managed care is away from group and staff models and toward contracts with networks of providers, and as relationships between medical groups or individual physicians and plans change frequently, managed care organizations face a significant challenge in developing systems to assist members in establishing a connection to the health care system and maintaining continuity of care.

Many plans are attempting to improve in this area by devoting increasing resources to population health practices and member outreach initiatives. Reminder cards, open houses, education initiatives, population segmentation and targeted "social marketing" campaigns, and collaboration with community resources such as family planning clinics, health centers and schools are all ways in which managed care organizations have attempted to increase "connection" to the system and utilization of wellness and prevention activities by their enrollees. Many have begun to experiment with the concept of "designated member representatives" – effectively administrative case managers – to provide an advocate for the member, to help the member navigate the system of care and to ensure that the member's multiple providers are working with full information and as collaboratively as possible.

C. Access to and Utilization of Care

Access and utilization of care is related to but not always determined by plans' coverage policies and benefit design. Women's health needs and health seeking behaviors as well as their responsibilities for coordinating care for family members heavily influence their utilization patterns. Needs and access issues differ significantly in different phases of life, presenting additional challenges for organizations pursuing integration and coordination of care. The example of adolescents is extremely telling in this area. Studies show that adolescents are likely to participate in preventive primary care activities related to sexuality and reproductive health if they can be assured that confidentiality will be preserved.[47]

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[43] Ibid.
[44] Ibid.
[45] Falik MM and Collins KS, eds. Women's Health, The Commonwealth Fund Survey, Baltimore: The Johns Hopkins University Press, 1996, p. 62.
[46] Ibid.
[47] Ford CA, Millstein SG, Halpern-Felsher BL, Irwin CE, "Influence of Physician Confidentiality Assurances on Adolescents' Willingness to Disclose Information and Seek Future Health Care," JAMA, 278:12, September 24, 1997,1029-1034.

By tracking and responding to both over and under-utilization of care, managed care organizations can begin to better address the factors that drive utilization of benefits.

Time and Cost Considerations

Access to care for women (and by extension for the family members whose care they coordinate) is also heavily affected by time availability[48]. Commonwealth study findings indicate that 29% of women 65 and under had not received care they knew they needed in the prior year due to time constraints. The availability of services at times and sites convenient to women is clearly an important factor in improving access. Many women's health advocates point to the time-sensitive nature of reproductive health services as a reason for allowing women access to obstetricians and gynecologists without a referral from a primary care practitioner.

Cost of care (including copays and deductibles) is also a strong predictor of utilization. The Commonwealth study indicated that one out of three insured women surveyed reported that cost (i.e. copays and/or deductibles) was a barrier to use of preventive services[49]. This issue is particularly pronounced among poor women, single parents (who often cover out of pocket costs for several family members) and older women, who are twice as likely to live in poverty as older men, and whose health plans may not cover prescription drugs[50]. A 1990 study of the 10 most common illnesses in persons with Medicare and Medigap coverage for which there is consensus about treatment found that 3 out of the 4 illnesses with the highest out-of-pocket costs were more common in women than men, while 4 of the 5 with the lowest out-of-pocket costs were more common in men[51].

Authorized Providers and Sites of Care

Managed care organizations have endeavored to constrain costs through transferring care delivery to the "least expensive appropriate setting." Though selective contracting and financial incentives linking providers with hospitals and clinics, they have attempted to lower overall costs of care by restricting use of inpatient care and expanding options for intermediate facilities and outpatient procedures and care. While this type of integration has been the source of significant savings in the industry, plans have not proceeded toward "resource optimization" without controversy and public sanction.

This issue has come under considerable controversy in women's health in the specific area of mastectomies, raising the broader question of how incentives can be aligned so that they optimize resources without compromising patient care. In the recent controversy over mastectomy treatment, consumers and advocates launched a very visible campaign opposing the increasingly common mco practice of providing mastectomies in outpatient clinics. The popular reaction against "drive-by mastectomies" (following closely on the heels of a similar campaign against strict limitations on maternity stays) highlighted public disapproval of health plans' attempts to constrain resources by establishing "arbitrary" length of stay limitations.

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[48] Wyn R, Brown ER and Yu H, "Women's Use of Preventive Services," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 67.

[49] Wyn R, Brown ER and Yu H, "Women's Use of Preventive Health Services," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 67.

[50] Reidy Kelch D, "The Health of Older Women in California," California Women's Health Project, CEWAER, June 1996, pp. 4 and 31. Note: Older women take an average of nearly six prescription drugs and three over the counter medications at the same time.

[51] Sofaer S, Abel E, "Older Women's Health and Financial Vulnerability: Implications of the Medicare Benefit Structure," Women Health 1990; 16 (3-4):47-67.

As noted earlier, because issues of reproductive health and social determinants of health (e.g. poverty and domestic violence) have been central to the development of the women's health movement, community health centers and reproductive health clinics have played an important role in providing services to women, and their important contributions as elements of a comprehensive primary care system have been noted by many. Managed care organizations have interacted with these providers in a variety of ways. Some managed care plans contract with and reimburse community based providers; many others refer members these providers with no mechanism for reimbursement. Still others have members who utilize these providers without referrals and thus without reimbursement. Selective contracting often overlooks community-based resources, including family planning clinics , STD clinics and community health centers because they are seen as providers of free care or care duplicative of that offered by the plan's "provider panel."

According to a 1994 GHAA/Kaiser Family Foundation survey 23% of HMOs had a contract with a family planning or abortion clinic.[52] Studies show that women and their families continue to rely on these providers of care even when they are insured. The reasons they do so range from proximity to their homes, to cost (copays can become prohibitive to many women, particularly if they are paying for frequent visits for multiple family members) to availability of services not covered under their insurance, to concerns about confidentiality, particularly in cases of domestic violence and reproductive care. Because plans will often not reimburse community health centers for services provided to their members, the utilization of these facilities and services by individuals covered by insurance plans results in "cost-shifting" from plans. The fact that over half of the plans participating in the above mentioned study indicate that they "intend to contract with these clinics in the future" points to a potential improvement in both financial and programmatic integration of these service providers as options for members of managed care plans.

Confidentiality

One area in which managed care financial arrangements are very beneficial relative to indemnity arrangements is in the protection of patient confidentiality. While most indemnity plans involve a "bill" for services which is submitted to both the primary plan holder and the employer, most services provided by HMOs and POS plans are provided without compromising the confidentiality of the recipient. This can be a very important factor to many women and adolescents, who may seek certain services only if they can be assured that they are doing so in a confidential environment.[53,54] For some individuals this may imply that the plan offers them the option of seeing providers outside of the network or providers other than those who serve their family members.

V. CONCLUSION

Integration issues and examples present many challenges for those working to improve the managed care system, particularly for those concerned about how it can more effectively serve the needs of women and lead to improved health status for women and those family members whose care they oversee. It is clear that the issues of integration and coordination of care commonly discussed in the context of managed care need to be broadened if they are to truly reflect the issues the comprehensive health needs and health-seeking behavior patterns of women.

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[52] Gold, RB and Richards CL, "Improving the Fit, Reproductive Health in Managed Care Settings," The Alan Guttmacher Institute, New York: 1996, p. 24.
[53] Ibid., p. 24.
[54] Ford CA, Millstein SG, Halpern-Felsher BL, Irwin CE, "Influence of Physician Confidentiality Assurances on Adolescents' Willingness to Disclose Information and Seek Future Health Care," JAMA, 278:12, September 24, 1997,1029-1034.

Managed care organizations interested in attracting and retaining members in an increasingly competitive market are attempting to design systems that allow for integration of care at the member level. By applying a combination of population health principles, effective use of the primary care team, and customer segmentation and outreach, several HMOs are attempting to move to a more consumer-focused model of care.

The "model" managed care plan would focus on using demographic and encounter information to identify patients in need of specific care or services and proactively reach members with the information and assistance necessary to ensure that they get the care they need. By offering preventive services with minimal cost sharing, the ideal managed care plan would remove an important financial barrier to an enrollee's receipt of recommended preventive screenings and care activities. Finally, the plan would consider how the primary users of services – women – can best access services once they are made available. Responses might be as simple as expanded clinic hours, locations and provider types and as complex as "case management" to coordinate a woman's multiple needs or the needs of all of the family members for whose health care she is responsible. Managed care organizations have begun to develop innovative approaches to the challenges of integration and coordination of care, and should be encouraged to work in partnership with consumers, clinicians and other advocates for women's health to incorporate the diverse and important needs of women into these improvements.

VI. PRINCIPLES AND RECOMMENDATIONS

Specific recommendations for improvement of integration and coordination of women's health in the managed care system rest on several guiding principles.

Principles:

- The managed care system will only deliver on its promise of optimizing member health while containing health care costs if it operates upon a foundation of coordinated, integrated care
- Comprehensive primary care addresses both biomedical and psychosocial factors in health and wellness
- Provision of comprehensive primary care and coordinated care of chronic diseases will improve health status and outcomes
- Women's' utilization of primary and preventive care is highly dependent on accessibility. As women are responsible for coordinating care for both themselves and most dependents, managed care organizations must not simply offer services, but must consider when, where and by whom services are being offered if they wish to achieve the full benefits of these interventions

Recommendations:

1. Managed care organizations should be encouraged to coordinate and integrate care around the needs of members. Advocacy groups should work with purchasers and accrediting organizations to define member survey questions that measure the extent to which managed care organizations are effectively integrating and coordinating members' care. These surveys should include services exclusive to women and should incorporate measures of both under and over-utilization. Because HEDIS measures are used widely by purchasers and consumers to asses health plan performance, the elements included strongly influence health plans' priorities in service delivery and quality improvement, and they serve as important leverage points for influencing both plan and provider behavior.

2. Recognizing that members, particularly women and adolescents, are likely to forego care because of issues of scheduling and confidentiality, managed care organizations should address these specifically as issues of access. When managed care organizations refer members to community-based clinics for "medically necessary" services not available within the plan (or recognize that many of their members are self-referring to these facilities), managed care organizations should be encouraged to provide an option that allows reimbursement for necessary primary and preventive care at alternative sites.

3. Plans should be encouraged by purchasers to provide information to all plan enrollees, not only to the primary plan subscriber, to ensure that those plan members covered as dependents are aware of the services available to them.

4. The division between primary care and routine reproductive care for women results in fragmentation of services, unnecessary duplication of services, inconvenience and cost for members and increased costs for insurers. To alleviate these problems:

   - Primary care training programs should incorporate the full range of primary health needs of men and women, and should prepare practitioners or design practitioner teams to provide for the totality of these needs.

   - Managed care organizations should ensure that primary care practitioners or teams made available to members are capable of providing the full range of necessary primary care services to avoid duplication that is costly to both plans and members. MCOs should be encouraged to require generalists who wish to provide primary care to women to demonstrate competency in basic aspects of gynecological care such as breast and pelvic exam, contraceptive management, and initial management of common gynecological problems.

5. Collaboration between the public and private sector of consistent standards and development of evidence-based, gender-specific practice guidelines should be encouraged.

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